Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure

Board of Registration in Pharmacy
239 Causeway Street, 5th Floor, Boston, MA 02114
617-727-9953 (office) 617-727-2366 (fax)
www.mass.gov/reg/boards/ph

APPLICATION FOR RELOCATION OF A PHARMACY OR PHARMACY DEPARTMENT

The following requirements apply to any pharmacy or pharmacy department relocating within the same structure or moving to a new location outside of the original structure. Prior to commencement of operation of any such facility, a complete application must be submitted to the Board of Registration in Pharmacy. All applications must consist of the following:

It is very important that the Manager of Record understands his / her responsibilities in the relocation of the facility. Therefore, the Board requires that a statement be submitted by the Manager of Record indicating that they will be present during the relocation of the controlled substances and that they are aware of their responsibilities in maintaining security during the transfer. This must be accompanied by documentation submitted by the Manager of Record attesting that the alarm and all motion detectors have been personally tested and are in working order, listing the line operator's identifier number and the time of the alarm test.

1. An Application for Relocation of a Community Pharmacy (enclosed and or available on the website) fully completed and signed by the registered pharmacist who is to manage and operate the pharmacy or pharmacy department.

2. If the pharmacy address changes, previously issued permits must be returned and a new registration number will be issued by the Board.

3. Certified blueprints or architectural plans drawn to scale and clearly designating the prescription area (pharmacy department shall be outlined in RED).

4. The prescription area must be at least 300 square feet; and must be so located that is not a passageway to other parts of the pharmacy.

5. The pharmacy must be physically independent and separate from any other business or store.

6. A check or money order made payable, in the proper amount, to the Commonwealth of Massachusetts.

No pharmacy and pharmacy department shall begin to operate in new location until the application has been approved by the Board and: 1) the pharmacist Manager of Record has received from the Board a permit number to manage and operate the pharmacy, and 2) has received a controlled substances registration number.

For complete information regarding relocation regulations, please refer to 247 CMR 6.04. If additional information is necessary, please contact the Board office at (617)727-9953.

To obtain a DEA number, please contact the Drug Enforcement Administration (DEA) office for an application. The address is:

J.F.K. Federal Building
Drug Enforcement Administration
Room E400
15 New Sudbury Court
Boston, MA 02203-0131
(617) 557-2200

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MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

RONALD PRESTON
SECRETARY

CHRISTINE C. FERGUSON
COMMISSIONER

APPLICATION FOR A RELOCATION OF A COMMUNITY PHARMACY

BOARD USE ONLY
Board_____
License #_____
Type_____
Cash #_____
Cash Date_____

I hereby apply for a permit to operate a store for the transaction of retail drug business in accordance with the provisions of Chapter 112, General Laws.

$351.00 licensure / application fee. Make check or money order for **$351.00** payable to the Commonwealth of Massachusetts. **This fee is non-refundable**.

1. Legal Name of Business._____

BOARD USE ONLY
Status Code_____ **Issue Date**_____**Lic. Exp. Date**_____

2. Previous Business Address (Street Address, City, State and Zip). _____
_____

3. Proposed Relocation Address for Business (Street Address, City, State and Zip._____
_____

4. Area Code and Telephone Number._____

5. All trade or business names ("D.B.A." names) used by same Corporation or by Licensee._____
_____

6. Type of ownership or operation (i.e., sole proprietorship, partnership, corporate distribution center for multi-unit (chain) pharmacy corporation)._____
_____
If corporation, please submit articles of corporation.

7. Name(s) and Social Security Number(s) of the owner(s) and/or operator(s) of the licensee. *Please indicate type of ownership-Partnerships: the name of each partner and name and address of partnership; Corporations: the name and title of each corporate officer and director, the corporate names, name and address of parent company, if any, and the State of incorporation's; Sole Proprietorships: the name of the sole proprietor and the name and address of the business entity.*

_____

_____

_____

8. Name of registered pharmacist previously charged with the management of the pharmacy.

_____

9. Registration number of previous manager._____

10. Name of registered pharmacist who is applying to manage the pharmacy._____

_____

11. Registration number of pharmacy manager applicant._____

12. Name(s) and registration number(s) of staff pharmacist(s) employed at pharmacy._____

_____

_____

_____

13. Have any of the applicant(s) and/or managers-in-charge had: 1) any convictions related to the distribution of drugs (including samples); 2) any felony convictions; 3) any suspension(s) or revocation(s) or other sanction(s) by federal, state or local governmental agency of any license or registration currently or previously held by the applicant or licensee for the manufacture, distribution, or dispensing of any drugs, including controlled substances? Have any applications for licensure been denied by any federal or state agency including any state boards of pharmacy? List and explain. Attach additional sheets if necessary.

_____

_____

_____

14. The applicant/licensee must notify the Board in writing of any changes in ownership or management within thirty (30) days of such change(s).

Affidavit (must be completed and notarized)

Pursuant to M.G.L. c. 62C, s. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

The applicant certifies that each person employed in any prescription drug distribution activity has the education, training, and experience, or any combination thereof, sufficient for that person to perform the assigned functions in such a manner as to provide assurance that the drug product quality, safety, and security will at all times be maintained as required by law.

I hereby state that I am the person authorized to sign this application for all licensure; that all statements are true and correct in all respects and are made under the penalties of perjury.

_____

Signature of pharmacist who is to manage the pharmacy or pharmacy department

_____

Date

_____

Social Security Number of managing pharmacist

Sworn and subscribed before me this_____day of _____

My commission expires_____ . _____

Notary Public

To be completed by the Board: Check $_____ Date_____ Number_____